Lafayette Pediatrics and Internal Medicine

Patient Name: _____ DOB: _____ Date: _____

Are you currently pregnant or breastfeeding? Yes No N/A

If yes, please talk with your provider before completing the rest of the questionnaire.

Do you experience any of the following symptoms? * Please circle all that apply.

Runny Nose Nasal Congestion Post Nasal Drip Sinusitis Asthma Diarrhea Fatigue

Pre-menstrual Syndrome Fibromyalgia Headache Watery Eyes Eczema/Atopic Dermatitis

Irritable Bowel Syndrome Itchy Eyes Skin Rash Vertigo Tinnitus Meniere's Disease

Other Symptoms: _____

*If you circled any of the symptoms listed above, please complete the rest of the questionnaire.

Family History of Allergy: Mother Father Brother/Sister Child None

Age symptoms began: Age 1-3 Age 3-12 before age 20 after age 20

My symptoms are worse: Spring Summer Fall Winter

Symptoms are present: 2-4 weeks 1-3 months 3-5 months Year Round

Allergic Triggers: House/Dust Mites Grasses Weeds Trees Molds/Yeast Cats Dogs Foods

Other: _____

Non-allergic Triggers: Tobacco Smoke Pot Pouri Home Cleaning Supplies Gas/Diesel Fumes

Cold Air Heat/Humidity Barometric Changes Medications Perfumes

Other: _____

I have been allergy tested before and found to be allergic to:

House/Dust Mites Trees Grasses Weeds Molds Cats Dogs

Other:_____ I have never been allergy tested

I was tested by: Skin Tests RAST ImmunoCap Other Blood Test

I take medication for asthma. True False

My asthma is: Mild Moderate Severe N/A

I had asthma in the past but "out grew" it. True False

I have never had asthma. True False

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History of severe reactions or anaphylaxis:

Never Bee or Wasp Stings Shellfish Peanuts Other Foods Medications Other _____

Medications I have used for my nasal symptoms:

Oral Antihistamines Decongestants (oral or nasal spray) Cromolyn Singulair Nasal Steroids

Atrovent Antihistamine nasal sprays Other: _____

I am allergic to: Milk and Milk products Wheat Corn Yeast Soy

Other Foods _____

Current Medical Illnesses: None Heart Lung Kidney Disease Skin IBS Diabetes

Autoimmune Disease Sinusitis Otitis Other:_____

Please list all medications you are currently taking, including vitamins, hormones, over the counter drugs and herbal supplements.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

I am interested in being allergy tested for:

Plants Pollens Molds Animal Dander Dust Mites Foods All

I am interested in ***Allergy Drops*** to control my allergies. Yes No

Name of person completing this form _____ Relationship to patient _____

Signature: _____ Date: _____